MEDRX

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Notice of Independent Review Decision

DATE OF REVIEW: 03/15/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of 12 additional sessions of physical therapy for the lumbar spine.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehablitation. This reviewer has performed this type of service in active practice and has been practicing for greater than 15 years.

REVIEW OUTCOME
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)
☐ Overturned (Disagree)
☐ Partially Overturned (Agree in part/Disagree in part)

The reviewer agrees with the previous adverse determination regarding the medical necessity of 12 additional sessions of physical therapy for the lumbar spine.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Records were received and reviewed from the following parties:
, MD, Sports & Physical Therapy, and

These records consist of the following (duplicate records are only listed from one source): Records reviewed from, MD, MD letter – 2/11/10 & 2/25/10, Patient Notes – 8/7/09-2/19/10, Progress Notes – 3/3/09-1/15/10, Written Script – 1/21/10; Initial Eval – 2/3/10; HDI denial letter – 7/21/09, 2/9/10, & 2/17/10;, MD radiology report – 3/3/09;, MD DDE report – 11/18/09; DWC69 – 11/18/09; , MD script – 7/27/09, Consult Note – 5/7/09, Nerve Conduction/EMG

report – 5/14/09;, DPT Re-eval report – 7/14/09, Plan of Care – 6/11/09 & 7/14/09, Script – 6/29/09, Communication – 6/29/09;, MD MRI report – 3/10/09.
Records reviewed: Sports & Physical Therapy WComp Request for Treatment – undated;, MD Progress Notes – 1/7/10, Patient Info – 5/22/09; Physical Therapy Pre-auth request – 6/12/09, 7/11/09, & 7/16/09, Initial Eval – 6/11/09.
Records reviewed from Sports & Physical Therapy: all duplicate records from above.

A copy of the ODG was not provided by the Carrier or URA.

PATIENT CLINICAL HISTORY [SUMMARY]:

This case involves an injured worker who sustained a work related injury to the lower back xx/xx/xx while working. He injured his lower back when he fell backward and landed on concrete. Pain developed in the right lower back. Numbness developed in the right lower extremity. He has a past history of back injury in 1998 with good recovery.

On March 3, 2009 at the Family Care Center He reported pain in the right lower back radiating into the right lower extremity. The diagnosis was lower back pain with radiculopathy. X-rays and an open MRI were scheduled. Prescriptions were given for Daypro, Ultram and Flexeril. On May 7, 2009. He was seen for neurology consultation by, M.D. Dr. diagnosed 724.2 lower back pain, rule out lumbar radiculopathy. He prescribed a Medrol Dosepak and Relafen. He requested continuing outpatient physical therapy 2-3 times per week for 2-3 weeks. Needle electromyography and nerve conduction studies were requested.

On May 14, 2009 Dr. performed electromyography and nerve conduction studies. The EMG was reported to be unremarkable except for prolonged insertional activity of the lower lumbar paraspinal muscles on the right, stating that "this may indicate a very minimal radiculopathy". Nerve conduction studies of the right peroneal, tibial and sural nerves were reported to be normal. The right H reflex latency was normal at 30.2 milliseconds and the left H reflex was similar at 30.1 milliseconds. Initial physical therapy evaluation and examination was done June 11, 2009 by, PT, DPT, Cert MDT. Therapy included therapeutic activities, therapeutic exercises, electrical stimulation, ultrasound and hot/cold packs. In the therapy note submitted June 29, 2009 He had received nine sessions of PT treatments and was pleased with the outcomes to date, reporting moderate back pain, stating that "his radicular s/s have started to centralize and his numbness has improved". Further therapy sessions were requested. Six further physical therapy visits were approved on 7/6/2009.

In a physical therapy reevaluation/re-examination July 14, 2009 the patient was reported to be making steady progress toward established goals. Greatest improvement was in functional performance and exercise tolerance. The reported pain level had improved from "moderate-severe" pain to "moderate" pain and the range of motion limitation in flexion had improved from "moderate" to "minimal". However, the back pain was reported to be 5/10 at rest and 8/10 with activity before the treatment sessions and after completion of the therapy sessions (i.e. no change). The neuro motor and sensory integration had not changed in response to the therapy sessions. Although range of motion limitation in flexion had

improved from "moderate" to "minimal", no improvement was documented in right lateral flexion, left lateral flexion or extension. Treatment goals were updated.

The request for 12 additional physical therapy sessions was denied on July 21, 2009. The Family Care Center progress note August 3, 2009 documented progress in response to therapy, noting that the request for further therapy had been denied. A note was entered at the Family Care Center August 14, 2009 affirming that a functional capacity evaluation had been approved for August 18, 2009. Results of the functional capacity evaluation were not made available for this review. On September 17, 2009 Dr. saw Him for follow-up, noting that further physical therapy had been denied. He was taking some anti-inflammatory medications and intermittent Darvocet and was trying to do his physical therapy exercises at home. He was unable to return to his current work functions. On physical examination, right straight leg rising was positive. Some weakness was noted in the right lower extremity. Dr. stated that He would consider having epidural injections to his back. Follow up with Dr. was expected on December 16, 2009.

On October 2, 2009 Dr. recommended continuing the anti-inflammatory medications and the home therapy. She mentioned that she would recommend evaluation by an occupational therapist or pain management therapist regarding epidural injections. On October 16, 2009 He stated that he would like to see about an epidural injection. Dr. planned to refer Him to Dr. for further evaluation. According to the note, He had already had the functional capacity evaluation.

A physical therapy initial evaluation/summary was submitted 02/03/2010, wherein active and passive modalities were proposed, with stated goals to improve trunk flexion, forward reaching and object pick up, improve straight leg raising measurements, decreased pain to enable tolerance of therapy and a home exercise program, and to improve strength. On November 18, 2009 the patient was seen by, M.D. for a designated doctor examination. Dr. found the patient not to be at MMI. He recommended four weeks of physical therapy (aggressive three times per week). He also recommended consideration for epidural steroid injections (ESI),

On December 28, 2009 the case manager notified Dr. office via telephone that the designated Dr. had recommended four weeks of aggressive physical therapy three times per week. The case manager wanted to know if Dr. had requested the therapy for precertification. On January 15, 2010 He stated that he preferred to go to Waco for therapy, as it was closer to home. Dr. saw him for follow-up January 7, 2010. On examination, there was tenderness to palpation over the mid lumbar region of the back. Strength was normal, reflexes were normal. Coordination was intact, gait steady (stiff at his waist). Dr. agreed with going to PT and thought that an ESI would help.

On January 21, 2010 Dr. again prescribed physical therapy evaluation and treatment with a diagnosis of lumbosacral radiculitis. The therapist's Initial Evaluation/Summary was submitted February 3, 2010. The therapist noted that He had not had any injections and did not want them. The proposed treatment plan included active and passive therapy modalities, home exercise program with progression, kinetic and therapeutic exercises, and functional

exercises, progressing as tolerated. Specific treatment goals were to improve trunk flexion and forward reaching, to improve straight leg rising, to decrease lower back pain and right lower extremity pain, to increase right lower extremity strength and segmental stability, and to prove activity tolerance.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

According to the ODG physical therapy guidelines for Sciatica: Thoracic/lumbosacral Neuritis/radiculitis, unspecified (ICD9 724.3; 724.4): 10-12 visits over eight weeks. In addition to the 16 therapy visits previously authorized, 12 additional visits (three times a week for four weeks), were requested. The proposed 12 additional therapy sessions exceed amount recommended in the ODG Guidelines.

Although the clinical records pertaining to the results of the 16 therapy sessions documented that the reported pain level had improved from "moderate-severe" pain to "moderate" pain and the range of motion limitation in flexion had improved from "moderate" to "minimal", the following measurements did not change in response to physical therapy: Back pain: reported to be 5/10 at rest and 8/10 with activity before the treatment sessions and after completion of the therapy sessions (i.e. no change). The neural motor and sensory integration had not changed in response to the therapy sessions. Although range of motion limitation in flexion had improved from "moderate" to "minimal", no improvement was documented in right lateral flexion, left lateral flexion or extension.

There are a number of overall physical therapy philosophies that may not be specifically mentioned within each guideline: (1) As time goes by, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency; (2) The exclusive use of "passive care" (e.g., palliative modalities) is not recommended; (3) Home programs should be initiated with the first therapy session and must include ongoing assessments of compliance as well as upgrades to the program; (4) Use of self-directed home therapy will facilitate the fading of treatment frequency, from several visits per week at the initiation of therapy to much less towards the end; (5) Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy); & (6) When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted…

Exceptional factors have not been addressed.
The pain has lasted more than one year and can be classified as chronic pain. The patient has lost his job. His functional capacity has not improved sufficiently for him to return to the same type of work. He has reported difficulty with sleeping. He continues to require medications for pain relief. According to therapy notes he has been highly motivated to succeed in therapy. The pain has not resolved in response to 16 sessions of primary therapy.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**